

THE DO'S OF DOCUMENTATION FOR HOSPICE

FORMS:

- All hospice forms / notes need to be signed and dated by the appropriate person(s).

ADVANCED DIRECTIVES:

- Document if the patient has an Advanced Directive. Request a copy for the clinical record and document each request made.

PAIN:

- Pain assessments should be conducted AT EACH VISIT with clear documentation of findings, interventions and any contact with physician.
- Document patient and family education and understanding regarding pain and symptom management.
- Document patient compliance based on appropriate monitoring and effectiveness of drug therapy.
- Document and monitor any new medications, changes in dosage and discontinued medication.
- Document teaching and understanding of any new medications, changes in dosage or discontinued medication.
- Document the effectiveness of any new medication, changes in dosage and discontinued medications during subsequent visits.
- Document a clear and concise description of patient pain.

MEDICATION:

- Document all medications (prescribed, OTC and herbal) on the patient's medication list.
- Physician orders for "as needed" medications should include the reason for administration
- Document any changes in medication and update this change on the medication list and ongoing plan of care.
- Document that all medications were reviewed with the patient and the family.
- Assess whether the patient/family are capable to administer medications. Document results of that assessment – identify the patient or family member(s) who will administer the medications and their capability.
- Document misuse (or suspected misuse) of a controlled substance and clearly document any contact with the physician or other appropriate person(s).
- Document the date, medication name, strength and quantity, signature of hospice staff and signature of person receiving a controlled substance medication when delivered to the patient's home.

- Document the patient/family received agency policies and procedures regarding the management of controlled drugs when applicable.
- Document any disposal of controlled substances. Documentation should include name of medication, strength and amount destroyed. Documentation should include signature of the hospice staff and signature of the witness.
- Documentation should clearly identify when a new prescription medication is found in the home. The documentation should include the name of the medication, dosage, frequency and route. Without this specific documentation we would expect to see a physician order.

SUPERVISION OF HOSPICE AIDE:

- Document supervision by the RN every 14 days (aide does not have to be present).
- Documentation should clearly identify whether the aide is following the tasks as assigned by the RN.
- Document supervision by the RN during an annual on-site visit with the aide.

SUPERVISION OF THE LPN:

- Documentation by the RN must include a monthly, on-site visit to the patient for the purpose of evaluating whether the LPN is providing care as directed by the Plan of Care (LPN does not have to be present).

WOUNDS:

- Assess / document wound measurements weekly. If more than one wound, documentation should be specific to each wound site.
- Assess / document location, size, odor, drainage, appearance of wound(s) and surrounding skin.
- Assess / document stage of pressure ulcers.
- Document identification of the person(s) responsible for the day to day wound care.
- If patient/family are providing wound care, document education and a return demonstration.
- Assess/ document if patient/caregiver are compliant with providing wound care as ordered by the physician.
- Document specific treatment provided to each wound.

REVOCATION:

- Document the reason the patient chose revocation versus other options.
- Document the IDG was informed of revocation.
- Document a discharge summary was sent to the physician.

DISCHARGE:

- Document reason for discharge.
- Document discussion with the patient/family/IDG.
- Document a discharge summary was sent to the physician.

NURSING FACILITY:

- Document a single, coordinated plan of care in both the hospice and nursing home clinical record.
- Document updates taken to the facility.
- Documentation should identify the roles of each provider. (Example: who is providing the catheter changes, wound care, aide visits, etc.)
- Document not only the frequency but the exact days the hospice aide/facility aide will provide personal care.

ON-CALL:

- Documentation should include the exact date and time of:
 1. The original call.
 2. The response to the call.
 3. The follow up to the call.

***The above information is **only a small part** of the documentation requirements to determine compliance with the Conditions of Participation and to assure quality nursing care.

Remember...if it is not documented it is NOT done!!!

(Revised March, 2013)